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No. 03-1202

In The

Supreme Court of the United States

HEWLETT-PACKARD COMPANY
EMPLOYEE BENEFITS ORGANIZATION
INCOME PROTECTION PLAN,

Petitioner,

v.

DONALD JEBIAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF IN OPPOSITION

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INTRODUCTION

This is a case where ERISA long term disability benefits were denied, the claimant administratively appealed, and his appeal was ignored by the ERISA plan administrator for eleven months.

The denial of benefits was based on a finding by the plan administrator, Voluntary Plan Administrators, Inc. (VPA), that respondent, Donald Jebian, was not disabled. VPA's finding was contrary to the opinion of every doctor that examined the plaintiff or reviewed his medical records. VPA never had the medical records reviewed prior to denying the benefits, nor at any time after. The denial was based on a vocational report, previously rejected by VPA, written by a person whose expertise in the field is unknown, and based on unknown evidence and, VPA claimed, on a Functional Capacity Examination (FCE). In fact the FCE found that Mr. Jebian could not sit for longer than 20 minutes on an occasional basis, and could not do any forward reaching, pushing, pulling, or typing.

Contrary to the defendant's suggestion that Jebian was informed that VPA needed specific medical records and was waiting for Jebian to obtain them (Petition 7), VPA never asked Jebian to get the records, rather it wrote Jebian that it (VPA) would obtain the records. Further, the letter about the missing records was not sent by VPA to Jebian until March 15, 1999, 119 days after he administratively appealed (Pet. App. 7a n.4.) and VPA did not attempt to get the records until March 18, 1999, 122 days after the administrative appeal. ER 10. Finally, the "missing records" were in the possession of VPA by May 1999, four months before Jebian filed his complaint in the district court and five months before VPA's denial of the

administrative appeal. VPA did not seek a meaningful exchange of information with Jebian until after the expiration of time limits set by the plan and the then existing ERISA regulations. In fact, VPA, when specifically asked, refused to consider medical reports that Jebian thought important, and which the Court of Appeals found relevant.

A. STATEMENT OF THE CASE

1. The Plan. The Plan is self-funded. VPA is the claims administrator. ER 138. VPA is authorized by the Plan to decide administrative appeals of the termination of benefits. According to the Plan, VPA's discretion is limited to decisions made within specific time limits.

> "The Claims Administrator shall act upon each request for review within sixty (60) days after receipt thereof, . . . *In no event shall the decision of the Claims Administrator be rendered more than one hundred twenty (120) days after it receives the request for review*. . . . The Claims Administrator shall have the discretionary power to construe the language of the Plan and make the decision on review on behalf of the Organization. . . . *Within the time prescribed above, the Claims administrator shall give written notice of its decision to the claimant and the Organization*. . . . If a claimant has not received written notice that additional time is required for review is reached [sic] by the Claims Administrator, the claim shall be deemed to have been denied on review. If a claimant receives proper and timely notice that additional time is required for review, but does not receive written notice of the Claims Administrator's decision with respect to his or her claim within one hundred twenty (120) days after the Claims Administrator receives the

> request for review, the claim shall be deemed to have been denied on review." Emphasis added. ER 164-165.

To be eligible for benefits under the Plan, a claimant must meet the Plan's definition of total disability. He must be "continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience." ER 142.

2. Claim History. Donald Jebian was employed by Hewlett-Packard as a software engineer. ER 97. He began work for the company in October, 1983 and first stopped working because of disability resulting from back problems in May, 1995. On June 9, 1995 he had his first back surgery and a second back surgery on August 8, 1995.

On June 7, 1996, Jebian had surgery on his right shoulder to repair a torn rotator cuff. ER 126. On October 4, 1996, his left shoulder was operated on for a massive torn rotator cuff. ER 128. The left shoulder turned out to be irreparable. ER 33, 190, 191.

After trying to return to work twice, once in March 1996 and then again in May 1997 (ER 105), Jebian worked his last day for Hewlett-Packard on June 2, 1997. ER 113, 130. VPA handled each of the three off-work periods as separate claims.

On August 3, 1998, VPA wrote to Mr. Jebian that his disability benefits were being terminated. ER 120-122. On August 18, 1998 the Plaintiff administratively appealed the denial of benefits. ER 119. On the same date, he wrote to VPA asking that as part of the administrative appeal, the records in a prior claim be reviewed as well as the

report of a Dr. Stark which VPA already had in its possession as part of a prior claim. ER 93. Further argument and evidence was submitted by Jebian to VPA on November 11, 1998. Along with the November 11, 1998 letter, the plaintiff sent a report of a Dr. James W. Landes, orthopedist. ER 108-110.

Ten months passed with no ruling from VPA regarding the administrative appeal. On September 20, 1999 the complaint was filed in the district court.

To make a long story short, there has not been a single medical doctor that has ever examined Mr. Jebian with regard to his back and shoulder problems that has opined that he is anything other than totally disabled under the terms of the plan. ER 104, 200, 123, 54, 125, 131, 111-112, 88, 108-110. There has not been a single medical doctor that has ever reviewed his medical records that has opined anything other than that he is totally disabled. Neither the defendant nor VPA has ever had the plaintiff's medical records reviewed by a doctor. The sole basis for terminating the plaintiff's disability benefits appears to be a boiler plate "rehabilitation report." ER 120-122.

3. **The District Court Decision**. The district court granted summary judgement to the plan. It held that the standard of review was for abuse of discretion and that VPA did not abuse its discretion. In doing so, the district court made numerous critical clearly erroneous findings of fact many of which are discussed in the opinion of the Court of Appeals.

4. **The Court of Appeals' Decision**. The Court of Appeals reversed the decision of the district court, holding that the district court should have applied the de novo

standard of review. It reasoned that the plan language granted discretion to VPA so that normally its decisions would be reviewed by a court for abuse of discretion.

> "[B]ut the same instrument and the regulations that govern it set time boundaries within which that discretion must be exercised. We are just as bound by the Plan language deeming denial in the event that time limits are exceeded as we are bound by the Plan language that grants discretion to the Plan administrator. Decisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding. * * * [W]here the plan itself provides that a particular violation results in an automatic decision rather than one calling for the exercise of the administrator's discretion, that provision is as enforceable as the provision giving the administrator discretionary authority under other circumstances. Deference to an exercise of discretion requires discretion actually to have been exercised." Pet. App. 9a.

VPA did not make a decision on the administrative appeal during the time period in which, under the express words of the plan, it could exercise its discretion. Any decision that it made that it had no discretion to make under the plan was not entitled to discretionary review by the district court. The matter was remanded back to the district court for consideration under the de novo standard of review.

B. REASONS FOR DENYING THE PETITION

Hewlett-Packard is seeking certiorari based on an alleged split among the circuits regarding the interpretation

of a regulation that no longer exists. Before turning to the alleged split, Mr. Jebian wishes to address two fundamental problems with the petition, each of which, standing alone, warrant its denial. First, as explained in Part 1 below, the petition presents a question on a dead legal issue – an issue that has been superseded by a new Department of Labor regulation. Second, Part 2 discusses an impediment to review that is wholly ignored in the petition: the interlocutory nature of the Ninth Circuit's ruling below. Part 3 shows that even assuming these barriers to review did not exist, the split among the circuits posited by Hewlett-Packard is not genuine. Part 4 explains why the decision of the Ninth Circuit is correct.

1. The Department of Labor ERISA Regulation Has Been Revised and the Old Regulation Under Which the Purported Split Among the Circuits Developed and Under Which Mr. Jebian's Case Was Decided Has No Continuing Significance.

The relevant Department of Labor regulation that gave rise to the purported conflict among the circuits has been amended in ways that render irrelevant the legal issue on which Hewlett-Packard seeks review. Thus, even assuming that the conflict was, at one time, genuine and important, it provides no basis for granting review because it has no continuing importance.

In this case, a time limit of 60 days, with the possibility of an additional extension of 60 days, was imposed on deciding administrative appeals by a Department of Labor ERISA regulation. See 29 CFR §2560.503-1(h)(1)-(h)(2), (h)(4) (1998). Under the regulation, a failure to make a

timely decision resulted in the administrative appeal being "deemed denied." The issue presented by the present case and the other cases that have dealt with the regulation is: what is the correct standard of review to be applied by a court reviewing a "deemed denied" administrative appeal.

A new regulation, applicable to ERISA claims filed after January 1, 2002, has replaced the regulation involved in Mr. Jebian's case and all the other cases that Hewlett-Packard relies on for its argument that there is a split in the circuits. See 65 Fed. Reg. 70246, 70270 (Nov. 21, 2000) (codified at 29 CFR §2560.503-1(o) (2003)). The new regulation is different from the old regulation in several key respects, and those differences demonstrate that the question presented in the petition has no continuing importance.

First, the new regulation requires that administrative review of a claimant's appeal be conducted by an "independent" fiduciary, not by the person who made the initial denial decision or her subordinate. 29 CFR §2560.503-1(h)(3)(iii) (2003). This fundamental change is barely mentioned in the petition (at 3 n.1), but it underscores the Department of Labor's view that a full and fair review of the merits of an ERISA disability appeal is critically important and cannot be a rubber-stamp of the initial adverse determination. The new rule supports the conclusion that where an administrative appeal is concluded not on the merits, but by virtue of a failure to timely decide the appeal, district court review should be conducted de novo. A system that requires "independent" administrative review would be severely undermined if a "deemed denial," i.e., no administrative review, were to translate into deferential review by a court. The very independence

demanded in the new regulation would thus be negated. At the very least, it must be conceded that the new regulation requiring independent administrative reviews provides an entirely different legal backdrop for deciding the question presented, and the conclusions reached by the circuit courts under the old regulation provide little or no insight on how the issue will play out under the new one.

Second, and critically, as the petition notes in passing (at 3 n.2), the new regulation entirely eliminates the "deemed denial" concept. Instead, rather than continuing the fiction that the administrative appeal was acted upon, under the new regulation, the claimant is simply "deemed to have exhausted the administrative remedies under the plan," allowing the claimant to seek immediate judicial review. *id.* §2560.503-1(l) (2003). This change is highly relevant to the appropriate level of judicial review. With the notion of a "deemed denial" abolished, and thus without even a fictional decision before the trial court, it is difficult to see how a deferential, abuse-of-discretion standard can apply. After all, there would, by regulatory definition, be no decision or exercise of discretion to which the trial court could defer. This understanding forms part of the rationale for de novo review that the court below and other courts have applied in "deemed denial" cases. For present purposes, however, our point is not to defend this rationale in cases under the old regulation, but only to note that this rationale is far stronger as applied to cases under the new regulation, because the "deemed exhaustion" provision of the new regulation results in no "denial" at all. This justification for de novo review under the new regulation would likely attract uniform support from all circuits that may address the question in the future.

Finally, in promulgating its new regulation, the Department of Labor directly opined on the question presented. Hewlett-Packard, again in a footnote (at 21 n.8), acknowledges the Department's position that "the procedural minimums of the [new] regulation are essential to procedural fairness and that a decision made in absence of the mandated procedural protections *should not be entitled to any judicial deference.*" 65 Fed. Reg. at 70255 (emphasis added).

The question at the certiorari stage is whether the Department's view renders meaningless the alleged circuit split that developed under the old regulation. And it does. At the very least, the Department's view of the new regulation would surely require any circuit that had adopted abuse-of-discretion review for "deemed denials" to rethink its position. Recognizing that the Department's view would appear to deal its position (and its request for certiorari) a fatal blow, Hewlett-Packard makes the astounding claim that the Department's "statement [adopting de novo judicial review] is best understood as applicable to plans, such as the one in *Firestone*, that had not established procedures to comply with ERISA . . . and its implementing regulation." Pet. 21 n.8. Hewlett-Packard offers no reason why the Department's view should be "best understood" in this manner, nor could it, because the final rule says nothing of the sort. Nor would such a position make sense, since an ERISA plan that adopts the required procedures but fails to abide by them should hardly be entitled to more judicial deference than one that fails to adopt them at all.

Moreover, Hewlett-Packard's position is laid to rest when one looks at the Department's commentary accompanying the *proposed* rule. In a section entitled "Consequences

of Failure to Establish and Follow Reasonable Claims Procedures," 63 Fed.Reg. 48390, 48397 (Sept. 9, 1998), the agency stated that, under the new regulation, a claimant who is not provided the procedural protections will be deemed to have "exhausted the administrative remedies available to him" "if the plan fails to provide or *abide by* procedures that meet the regulatory minimum standards." *Id.* (emphasis added). In this situation – explicitly including cases where the plan has established the minimal procedures but failed to "abide by" them – the claimant may go directly to court and "any decision that may have been made by the plan with respect to the claim is not entitled to the deference that would be accorded to a decision based upon a full and fair review that comports with the requirements of section 503 of the Act." *Id.*

Thereafter, in the agency's commentary accompanying the final rule, the Department addressed "[m]any commenters representing employers and plans" who argued against the deemed exhaustion provision and urged instead adoption of a "good faith compliance" or "actual harm" standard. 65 Fed.Reg. at 70255-56. The agency rejected those suggestions because it "believe[d] that plans should be held to the articulated standards as presenting a minimum procedural regularity that warrants imposing an exhaustion requirement on claimants." *Id.* at 70256. Thus, "[a]t a minimum, claimants denied access to the statutory administrative review process should be entitled to take a claim to a court under section 502(a) of the Act *for a full and fair hearing on the merits of the claim.*" *Id.* (emphasis added).

This regulatory history shows that the Department rejects the Hewlett-Packard's position on the merits. It also demonstrates that the Department's view on the

standard of judicial review is tied, at least in part, to the agency's new "deemed exhaustion" rule. It is thus very likely that all circuits, when faced with cases involving the *new* regulation, will adopt the agency's view that de novo judicial review is appropriate in cases like Mr. Jebian's.

In sum, the petition asks the Court to review a question posed by a dead regulation, which has been replaced by a new regulation that dramatically alters the legal landscape. Review should be denied on that ground alone.

2. Review Should Be Denied Because The Ninth Circuit's Decision Is Interlocutory.

Even if we were to assume away the obsolescence of the question presented, another fundamental barrier to review remains. Although this Court has jurisdiction under 28 USC §1254(1) to review interlocutory decisions of federal courts of appeals, it rarely does so. "Ordinarily, in the certiorari context, 'this court should not issue a writ of certiorari to review a decree of the circuit court of appeals on appeal from an interlocutory order, *unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause.*'" Robert L. Stern, et al., *Supreme Court Practice* §4.18, at 258 (8th ed. 2002) (quoting *American Construction Co. v. Jacksonville, T.&K.W. Railway Co.*, 148 U.S. 372, 384 (1893) (emphasis added)); see also, e.g., *Hamilton-Brown Shoe Co. v. Wolf Bros. Co.*, 240 U.S. 251, 258 (1916) (interlocutory decisions are reviewed only in "extraordinary cases"). The posture of this case is anything but "extraordinary." Mr. Jebian filed a garden-variety ERISA claim seeking the review of a long-term disability benefits determination in the federal

district court. The district court granted summary judgment to the defendant plan. The Ninth Circuit reversed and held simply that, because the district court erred in failing to review the plan's benefits denial on a de novo basis, Mr. Jebian's claim survives summary judgment and must be resolved on its merits by the trier of fact. The plan retains all defenses it may have and the trier of fact is free to find in favor of the plan on any permissible ground. If Hewlett-Packard prevails on the ultimate disability question or on any other dispositive ground, review on the question presented in the petition would not be necessary or appropriate.

Of course, Mr. Jebian believes that he will prevail on the merits. If that occurs, there will be a final judgment from which the plan may appeal and ultimately present the standard of review question, and any other federal issue, to this Court for resolution. This case is a less appropriate vehicle for immediate, interlocutory review than was true in *Virginia Military Institute v. United States*, 508 U.S. 946 (1993) ("*VMI*"), where the Court denied review because of the case's interlocutory posture. In *VMI*, the Fourth Circuit had issued a final decision holding that the Commonwealth of Virginia's sponsorship of a military college for men only was unconstitutional, but the district court had yet to rule on the appropriate remedy. The Court denied certiorari on the ground that the decision was not sufficiently final because the remedy phase had not been completed. See *id.* (Scalia, J., concurring). The Court recognized that there would be time enough to review the decision if that were necessary after the remedial portion of the case was decided. In fact, it later did so. *United States v. Virginia*, 518 U.S. 515 (1996). Here, of course, there is no decision regarding liability, let

alone the appropriate remedy, and thus interlocutory review is particularly inappropriate.

3. There Is No Real Split Among The Circuits.

The issue raised by the Ninth Circuit's decision in this case is whether or not there is a change in the standard of review from arbitrary and capricious (sometimes referred to as abuse of discretion or deferential review) to de novo when a plan administrator, granted discretionary powers with regard to the granting of claims, fails to timely decide administrative appeals. At first glance, a review of the decisions dealing with the question indicates a conflict in the answers given by some of the circuit courts. A closer review, however, shows otherwise. The various courts are working their way to a consensus.

There is no conflict between the Ninth Circuit's ruling below and the opinions of the Tenth Circuit in *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003) and the Third Circuit in *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002). Indeed, decision below was in part based on the reasoning in both *Gilbertson* and *Gritzer*. All three hold that the failure to timely decide an administrative appeal calls for a de novo review of a denial of benefits. All three cases recognize the impossibility of reviewing for abuse of discretion a denial of benefits that is not the result of an exercise of discretion but rather the passage of time. *Gilbertson*, which followed *Gritzer*, recognized an exception to the rule when there is an ongoing productive investigation of the claim in which both parties participate. The decision below recognizes the exception.

McGarrah v. Hartford, 234 F.3d 1026 (8th Cir. 2000) held that while a failure to render a timely decision in an administrative appeal was a serious procedural irregularity, it would not necessarily "strip a plan administrator of the deferential standard of review." It was pointed out, under the facts of that case, that the initial decision to deny benefits followed a review of all of the evidence submitted to the administrator and that no new evidence was submitted by the claimant when he administratively appealed. Therefore, there was an actual decision, that considered all of the claimant's evidence, made by the administrator that was the result of its exercise of discretion that the Court could review for abuse of that discretion. If there had been substantial new evidence submitted by the claimant at the time of the administrative appeal, the standard of review would probably have been de novo since the only decision of the administrator, a decision made prior to the administrative appeal, would not have taken that additional evidence into consideration.

This analysis is supported by the Eighth Circuit's later decision in *Seman v. FMC Corporation*, 334 F.3d 728 (8th Cir. 2003). The Court held that de novo review applied to a denial of benefits when the plan in question granted full discretion to the administrator but the administrator had failed to timely decide the administrative appeal. The Court distinguished its earlier decision in *McGarrah* by pointing out that Seman, unlike McGarrah, submitted substantial amounts of medical evidence in connection with his administrative appeal, evidence that was not before the plan administrator when it initially denied his appeal. Thus, a deferential review of the administrator's denial of benefits could not be done since that exercise of the administrator's discretion failed to consider

the substantial newly submitted evidence. So the Eighth Circuit, in the end, is in conformity with the Third, Ninth, and Tenth. In order for there to be a review for abuse of discretion, there has to be a decision that is the result of the exercise of discretion granted by the plan. Otherwise, the standard of review is de novo.

The Sixth Circuit in *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir. 1988) held, without much discussion or analysis, that the standard of review remains abuse of discretion "whether the appeal is actually denied or deemed denied." Twelve years later that circuit had an opportunity to examine its holding in *Daniel*. Although it did not need to reverse the holding, in dicta it stated that there is "undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner." *University Hospitals of Cleveland v. Emerson Electric Co.*, 202 F.3d 839, 846 n.3 (6th Cir. 2000). Thus, the Sixth Circuit seems to be moving in the direction of a consensus with the others that have faced the issue, and it would have a clear basis for doing so under the new regulation. See *supra* Part 1.

Southern Farm Bureau v. Moore, 993 F.2d 98 (5th Cir. 1993), is a case that is at odds with the present state of ERISA litigation. One can safely say that it was wrongly decided. The claimant was never given an opportunity to ask for an administrative appeal or to submit additional evidence challenging the original denial of benefits. The claimant was denied a full and fair review by way of administrative appeal. Furthermore, the Court refused to consider the new evidence that the claimant had and that, in a normal situation, she could have presented to the plan administrator and ultimately to the trial court. The plan

in that case, unlike all of the other cases that are discussed, did not grant discretionary authority to the plan administrator. The Fifth Circuit held that review of factual findings, as opposed to plan interpretations, of a plan administrator, regardless of whether or not discretion is granted to the administrator, are always to be reviewed for abuse of discretion. *Southern Farm* is in conflict, on numerous issues, with most ERISA decisions that temporally follow it. For example, most Circuits hold that de novo review, when it applies, covers both interpretations of a plan and the factual findings of the plan administrator.

4. The Court of Appeals' Decision Is Correct.

"ERISA further requires that plan procedures 'afford a reasonable opportunity for a full and fair review' of dispositions adverse to the claimant." *Black & Decker v. Nord*, 538 U.S. 822, 830 (2003). Given this entitlement to a full and fair review, the duty of the plan administrator is more than just to reach a decision that is not arbitrary and capricious. It is to reach a correct decision, a decision based "on the merits of the claim." 29 CFR §2560.503-1(l) (2003). One of the safeguards to reaching a correct decision is administrative review.

Application of the arbitrary and capricious standard of review by a court to a decision that was not actually made after a full and fair consideration of the evidence, but which simply resulted from a claim being deemed denied by a failure to timely decide it, would encourage claim administrators to make no decisions at all. This would delay much needed benefits and require the courts to sift through the evidence, once the frustrated claimant has

filed suit, to come up with judicial rationales for denials that would pass the arbitrary and capricious test. The courts would in effect become the decision makers and, rather than looking for the correct decision in a given case (as administrators are supposed to do), judges would be looking for all possible ways to justify denials of benefits. The trial judge would become a biased plan administrator. Claims would be examined with an eye to finding reasons for their denial rather than to reach decisions on the merits.

Time limits established by ERISA regulations recognize that a person who needs ERISA benefits, needs them sooner rather than later. A disabled person is without work and lucky to be living on savings. Oftentimes a person in need of medical treatment needs it now; tomorrow may be too late. While there may be times when a plan administrator is justified in taking longer than the time set forth in the regulation to make a decision, it must be recognized that such delays are always at a cost to the needy claimant.

In this case, there was no justification for a delayed decision at all. VPA did not seek what it calls the missing medical evidence until 122 days after the administrative appeal. VPA, although it received the "missing medical evidence" in May 1999, had still not made a decision regarding the administrative appeal at the time Jebian finally filed the complaint, on September 20, 1999, four months later. At no time did VPA ever ask for the additional time that the regulations allowed it to ask for. It just took its time at doing nothing and would have continued to do nothing had not the plaintiff filed the complaint in district court. The ruling of the Ninth Circuit gives plan

administrators a powerful incentive to reach decisions in a timely fashion.

The argument, made by the defendant, that plan administrators will make erroneous denials if forced to meet the time limits mandated by the regulation, is fallacious for several reasons. First of all, nobody knows how many denials, timely but without a full and fair review, are presently made by administrators simply so that they can meet the ERISA time limits. Let's face it, no plan administrator admits to making a decision without a full and fair review. If the number is small, it means that the problem posed by the defendant is also small. If the number is large then defendant's argument goes too far. It means that either the ERISA time regulations should be eliminated altogether or the arbitrary and capricious standard of review should be eliminated. The two are incompatible. Yet, we know that the Department of Labor has decided that the time limits are important to the administration of ERISA claims. In fact, the Department's new regulation shortens the time in which a decision must be made from 60 days to 45. 29 CFR §2560.503-1(f)(3) (2003), thus rejecting implicitly Hewlett-Packard's claim that plans need more time to conduct full and fair administrative reviews.

The defendant's argument is wrong for a second reason. Erroneous timely denial decisions, according to the argument, would be made so that administrators could preserve the arbitrary and capricious standard of review. The argument assumes that the administrators are concerned about being forced to wrongly deny claims. It assumes the good faith of the administrators and their strong desire to do the right thing vis-a-vis claimants. The answer to the argument's dilemma between a timely

decision and a just decision is simple. If a plan administrator makes what it knows to be a timely decision that may be wrong, it has months until the plaintiff files the complaint and the matter works its way through the court to a trial date, in which to fully examine the claim in every detail. If it finds that its denial was wrong, it can change its decision and pay the benefits due.

In cases where the plan administrator has not denied the administrative appeal before the filing of a lawsuit, it is almost impossible to apply the arbitrary and capricious standard of review. This case is a good example of that impossibility. A report by a Dr. Stark (ER 104, 200), that the plaintiff requested the administrator to consider (ER 93) and found relevant by the Court of Appeals, was never considered by the defendant even in its final post complaint denial letter. A report by a Dr. Landes (ER 108-110) was not considered by the defendant until the post complaint denial letter. SER 60-64. The plaintiff's arguments that the Rehab West report was faulty were never considered at all. ER 106. Which decision of the defendant was the court supposed to review for abuse of discretion? The pre-complaint decision that the plaintiff administratively appealed from or the post complaint decision? If we say that the court should apply abuse of discretion review to the pre-complaint decision, is justice served by a court ignoring the plaintiff's evidence and argument that was raised in the administrative appeal? Surely nothing could more clearly be a denial of a full and fair review of the claim. Not only did the defendant ignore the plaintiff's evidence and argument but now a court will also.

Abuse of discretion review cannot apply to a post complaint decision either. By the time of that decision the parties, being that they are on the opposite sides of a

federal lawsuit, are polarized in adversarial positions. ERISA and its abuse of discretion standard of review assumes that a fiduciary is searching for the truth rather than a litigant presenting a justification for its actions. Applying the arbitrary and capricious standard of review to a post complaint denial of an administrative review fails to recognize that the post complaint denial is probably the result of a conflict of interest.

Finally, de novo review is the default standard of review. Only when plan documents confer a fiduciary with discretion to determine facts and interpret terms of the plan does the abuse of discretion standard of review apply to a court's review of a denial of ERISA benefits. In this case discretion is granted to VPA only with regard to decisions that it makes within specific time limits. The Ninth Circuit's decision recognized that VPA's decision was outside of the time limit in which it was required to exercise discretion under the terms of the plan, regardless of the existence of the regulation. Thus, even if we ignore the old regulation, VPA's decision was not entitled to deferential review. The grant of discretion in the plan did not extend to decisions made after a specific time.

In *Rush Prudential v. Moran*, 153 L.Ed.2d 375, 385 (2002) this Court wrote with regard to deferential review and ERISA cases, "Not only is there no ERISA provision directly providing a lenient standard of judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the statute is silent, we held that a general default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion,

(citation omitted). Nothing in ERISA, however, requires that these decisions be so 'discretionary' in the first place; whether they are is simply a matter of plan design or drafting of an HMO contract."

Most ERISA plans do not have specific time limits written into them. In this case time limits are in the plan documents; they limit the discretion granted to VPA; they are contractual. No grant of discretion is given to the plan administrator in this case for decisions made outside of the time limits set forth in the plan. Decisions made without discretionary authority are not entitled to abuse of discretion review by the courts whether they are timely or not. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). The Ninth Circuit's decision simply recognizes the fact that VPA's decision to deny Mr. Jebian's administrative appeal was not entitled to differential treatment by the courts simply because the plan documents do not grant discretion to VPA to make the decision.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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